

<i>SERFF Tracking Number:</i>	<i>ICCI-127664494</i>	<i>State:</i>	<i>Arkansas</i>
<i>Filing Company:</i>	<i>American Medical and Life Insurance Company</i>	<i>State Tracking Number:</i>	<i>49909</i>
<i>Company Tracking Number:</i>	<i>AML I OPTIONAL RIDERS</i>		
<i>TOI:</i>	<i>H14G Group Health - Hospital Indemnity</i>	<i>Sub-TOI:</i>	<i>H14G.000 Health - Hospital Indemnity</i>
<i>Product Name:</i>	<i>AML I Optional Riders</i>		
<i>Project Name/Number:</i>	<i>AML I Optional Riders /AML I Optional Riders</i>		

Filing at a Glance

Company: American Medical and Life Insurance Company

Product Name: AML I Optional Riders SERFF Tr Num: ICCI-127664494 State: Arkansas

TOI: H14G Group Health - Hospital Indemnity SERFF Status: Closed-Approved-Closed State Tr Num: 49909

Sub-TOI: H14G.000 Health - Hospital Indemnity Co Tr Num: AML I OPTIONAL RIDERS State Status: Approved-Closed

Filing Type: Form

Reviewer(s): Rosalind Minor
 Disposition Date: 10/04/2011
 Disposition Status: Approved-Closed

Author: Brenda Dawson
 Date Submitted: 09/28/2011

Implementation Date Requested: On Approval

Implementation Date:

State Filing Description:

General Information

Project Name: AML I Optional Riders
 Project Number: AML I Optional Riders
 Requested Filing Mode: Review & Approval
 Explanation for Combination/Other:
 Submission Type: New Submission
 Group Market Type: Association
 Filing Status Changed: 10/04/2011
 State Status Changed: 10/04/2011
 Created By: Brenda Dawson
 Corresponding Filing Tracking Number: ICCI-127126793
 Filing Description:

Status of Filing in Domicile:
 Date Approved in Domicile:
 Domicile Status Comments:
 Market Type: Group
 Group Market Size: Large
 Overall Rate Impact:

Deemer Date:
 Submitted By: Brenda Dawson

Please find attached to the form schedule tab the Skilled Nursing Facility Benefit Rider and the Ambulance Services Benefit Rider that will be offered with Group Accident and Sickness Hospital Indemnity Policy, AML I GRP LM 2.0 POL NE, previously approved by your Department on August 8, 2011 under SERFF Tracking Number: ICCI-127126793. These forms are new and are not intended to replace any form previously approved by your Department.

The Group Application AML I GRP LM 2.0 APP is being filed to include the optional benefit riders. This application will replace the previously approved one. The form number will remain the same because it has not been used yet. The Policy Benefit selection information on the Group Application is representative of the benefit options that will be made

SERFF Tracking Number: ICCI-127664494 State: Arkansas
Filing Company: American Medical and Life Insurance Company State Tracking Number: 49909
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Product Name: AMLI Optional Riders
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available to the group policyholder. The selections may change if future optional benefits are created and filed.

Insurance Compliance Consultants, Inc., is making this filing on behalf of American Medical and Life Insurance Company. A filing authorization letter is attached. All correspondence should be addressed to Insurance Compliance Consultants, Inc.

Company and Contact

Filing Contact Information

Brenda Dawson, Authorized Representative Brendadawson@inscompliance.com
3925 East State Street, Suite 200 815-316-6714 [Phone]
Rockford, IL 61108 815-986-2355 [FAX]

Filing Company Information

(This filing was made by a third party - insurancecomplianceconsultantsinc)

American Medical and Life Insurance Company CoCode: 81418 State of Domicile: New York
8 West 38th Street Group Code: Company Type:
Suite 1002 Group Name: State ID Number:
New York City, NY 10018 FEIN Number: 13-2562243
(646) 223-9300 ext. [Phone]

Filing Fees

Fee Required? Yes
Fee Amount: \$150.00
Retaliatory? No
Fee Explanation: \$50 per form
Per Company: No

COMPANY	AMOUNT	DATE PROCESSED	TRANSACTION #
American Medical and Life Insurance Company	\$150.00	09/28/2011	52228569

SERFF Tracking Number: ICCI-127664494 State: Arkansas
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Correspondence Summary

Dispositions

Status	Created By	Created On	Date Submitted
Approved-Closed	Rosalind Minor	10/04/2011	10/04/2011

SERFF Tracking Number: *ICCI-127664494* *State:* *Arkansas*
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Product Name: *AML I Optional Riders*
Project Name/Number: *AML I Optional Riders /AML I Optional Riders*

Disposition

Disposition Date: 10/04/2011

Implementation Date:

Status: Approved-Closed

Comment:

Rate data does NOT apply to filing.

SERFF Tracking Number: ICCI-127664494 State: Arkansas

Filing Company: American Medical and Life Insurance Company State Tracking Number: 49909

Company Tracking Number: AMLI OPTIONAL RIDERS

TOI: H14G Group Health - Hospital Indemnity Sub-TOI: H14G.000 Health - Hospital Indemnity

Product Name: AMLI Optional Riders

Project Name/Number: AMLI Optional Riders /AMLI Optional Riders

Schedule	Schedule Item	Schedule Item Status	Public Access
Supporting Document	Flesch Certification	Approved-Closed	Yes
Supporting Document	Application	Approved-Closed	Yes
Supporting Document	Authorization Letter 2011	Approved-Closed	Yes
Form	Ambulance Services Rider	Approved-Closed	Yes
Form	Skilled Nursing Facility Benefit Rider	Approved-Closed	Yes
Form	Policyholder Application	Approved-Closed	Yes

SERFF Tracking Number: ICCI-127664494 State: Arkansas

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TOI: H14G Group Health - Hospital Indemnity Sub-TOI: H14G.000 Health - Hospital Indemnity

Product Name: AMLI Optional Riders

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Form Schedule

Lead Form Number: GRP LM 2.0 ASR

Schedule Item	Form Number	Form Type	Form Name	Action	Action Specific Data	Readability	Attachment
Approved-Closed 10/04/2011	GRP LM 2.0 ASR	Certificate	Ambulance Services Amendmen Rider t, Insert Page, Endorseme nt or Rider	Initial			GRP LM 2 0 ASR _Ambulance Services Rider_ 8-31- 11.pdf
Approved-Closed 10/04/2011	GRP LM 2.0 SNF	Certificate	Skilled Nursing Amendmen Facility Benefit Rider t, Insert Page, Endorseme nt or Rider	Initial			GRP LM 2 0 SNF _Skilled Nursing Facility Benefit Rider_ 8-31-11.pdf
Approved-Closed 10/04/2011	AMLI GRP LM 2.0 APP	Application/ Enrollment Form	Policyholder Application	Initial			AMLI GRP LM 2 0 APP 9-8-11 clean copy.pdf

**American Medical and Life Insurance Company
New York, New York**

[OPTIONAL] Ambulance Services Rider

This Rider is made a part of the Policy/Certificate to which it is attached. [The consideration for this Rider is the application for this Rider and payment of any applicable premium.]

The Benefits provided by this Rider will not duplicate the Benefits provided under the Certificate and any other Rider.

The following Benefit is hereby added:

Ambulance Services Benefit:

We will pay the Ambulance Services Benefit, as shown below, up to the maximum number of conveyances as shown below, if a licensed professional ambulance company transports any Covered Person by ground or air transportation to or from a Hospital or between medical facilities, where treatment is received as the result of a Covered Sickness or Covered Accident. The Covered Person must incur charges while the coverage is in force for professional ambulance service to receive this benefit. The ambulance transportation must be within 90 days after a Covered Sickness or Covered Accident. We will pay this amount once per Covered Sickness or Covered Accident.

[Ambulance Services Benefit	[\$100 - \$1,000] per Covered Sickness/Accident per Covered Person
Maximum Number of Conveyances	[3-6] per Certificate Year per Covered Person]

There are no other changes to the Certificate.

TERMINATION

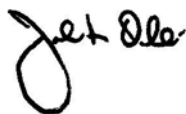
Coverage under this Rider will end on [the earliest of:]

1. the date [a Covered Person's] coverage under the Policy ends[; or
2. the premium due date coinciding with or next following the date We receive a written request to terminate this Rider].

This Rider is endorsed and made a part of the Policy/Certificate as of [its Effective Date] [September 1, 2011] [or] [Your Coverage Effective Date] [whichever is later].

This Rider is subject to all provisions of the Policy which are not in conflict with the terms of this Rider. Nothing in this Rider will be held to vary, alter, or extend any of the terms, conditions, provisions, agreements, or limitations of the Policy other than stated above.

IN WITNESS WHEREOF, the Insurance Company has caused this Rider to be signed by:



Chairman, President and CEO



Vice President & Chief Compliance Officer

**American Medical and Life Insurance Company
New York, New York**

[OPTIONAL] Skilled Nursing Facility Benefit Rider

This Rider is made a part of the Policy/Certificate to which it is attached. [The consideration for this Rider is the application for this Rider and payment of any applicable premium.]

The Benefits provided by this Rider will not duplicate the Benefits provided under the Certificate and any other Rider.

The following Benefit is hereby added:

Skilled Nursing Facility Benefit:

We will pay the Skilled Nursing Facility Benefit, as shown below, up to the maximum number of days as shown below, if any Covered Person incurs charges for and is Confined in a Skilled Nursing Facility, after a Hospital Confinement of three days or more, due to injuries received in a Covered Accident or due to a Covered Sickness. Payment of this benefit will be in lieu of any Hospital Confinement benefit.

[Skilled Nursing Facility Benefit
Maximum Benefit

[\$100 - \$1,000] per day of confinement
Up to [60-90] days per Calendar Year per Covered Person]

We will not pay this benefit for:

- Emergency room treatment;
- Outpatient treatment; or
- Confinement to an Observation Unit.

There are no other changes to the Certificate.

TERMINATION

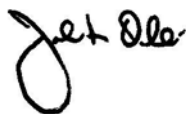
Coverage under this Rider will end on [the earliest of:]

1. the date [a Covered Person's] coverage under the Policy ends; or
2. the premium due date coinciding with or next following the date We receive a written request to terminate this Rider].

This Rider is endorsed and made a part of the Policy/Certificate as of [its Effective Date] [September 1, 2011] [or] [Your Coverage Effective Date] [whichever is later].

This Rider is subject to all provisions of the Policy which are not in conflict with the terms of this Rider. Nothing in this Rider will be held to vary, alter, or extend any of the terms, conditions, provisions, agreements, or limitations of the Policy other than stated above.

IN WITNESS WHEREOF, the Insurance Company has caused this Rider to be signed by:



Chairman, President and CEO



Vice President & Chief Compliance Officer

American Medical and Life Insurance Company
8 West 38th Street, Suite 1002, New York, New York

POLICYHOLDER APPLICATION
FOR GROUP ACCIDENT AND SICKNESS HOSPITAL INDEMNITY INSURANCE

1. Name of [Employer/Association] _____ Group #: _____

2. Address (Street) _____

City: _____ State: _____ Zip Code: _____

3. Phone Number: _____ 4. Plan Administrator: _____

5. Nature of [Business/Association]: _____ 6. Effective Date of Coverage: _____

7. Initial Enrollment: Start Date _____ Stop Date: _____

8. Subsequent Annual Enrollment Period, Subject to the Agreement of the Policyholder and American Medical and Life Insurance Company

Start Date _____ Stop Date: _____

9. [Waiting Period: ____ Days

If this is different by employee/member class or for the initial and future enrollments, please indicate: _____]

10. Eligibility Period: _____

11. Eligible Class

[Employer Group

☐ All active employees working a minimum of _____ regularly scheduled hours per week, per year.

(A minimum of [15 hours] per week is required.)

☐ Are there any special eligibility or employee class requirements or restrictions? If so, please describe.

The participation requirement is the greater of [50] enrolled lives or [50%] If premium is non-contributory must have 100% eligible employee participation. If contributory not less than 50% of eligible employees or less than 50 eligible employees.

Number of eligible employees: _____ (Must be greater than 50). Number Enrolled: _____

Is there any employer contribution? ☐ Yes ☐ No If yes, what percentage? _____ %

Named Insured Only: ☐ 100% ☐ 75% ☐ 50% ☐ _____ (other)

Named Insured and Spouse: ☐ 100% ☐ 75% ☐ 50% ☐ _____ (other)

Family: ☐ 100% ☐ 75% ☐ 50% ☐ _____ (other)

Plan Applied For:

Employee Class: _____]

[Association Group

All active members of [ABC Association] as determined by bylaws or charter of the Association]

Number of eligible members: _____

Is there any association contribution? ☐ Yes ☐ No If yes, what percentage? _____ %

Named Insured Only: ☐ 100% ☐ 75% ☐ 50% ☐ _____ (other)

Named Insured and Spouse: ☐ 100% ☐ 75% ☐ 50% ☐ _____ (other)

Family: ☐ 100% ☐ 75% ☐ 50% ☐ _____ (other)

Plan Applied For:

Member Class: _____]

12. Policy Benefits Selected: (See Rate Manual for Options)

[Accident Medical Expense Benefit]	
Accident Medical Benefit Deductible	[\$50-\$500] per Certificate Year per [Covered Person] [Family]
Accident Medical Benefit	[80%-100%]
Accident Medical Maximum Benefit	[\$500-\$10,000] per Certificate Year per [Covered Person][Family]
[Critical Illness Benefit]	
Heart Attack	100% of Benefit
Invasive Cancer– diagnosis more than 30 days after effective date	100% of Benefit
Invasive Cancer – diagnosis within the first 30 days after effective date	10% of Benefit
End-Stage Renal Failure	100% of Benefit
Stroke	100% of Benefit
Major Organ Transplant	100% of Benefit
Cancer In Situ– diagnosis more than 30 days after effective date	25% of Benefit
Cancer In Situ – diagnosis within the first 30 days after effective date	2.5% of Benefit
Maximum Benefit	[\$5,000][\$10,000][\$15,000] per Original Diagnosis per [Covered Person][Family]
[Dental Benefit]	
Prophylaxis (Cleaning) CDT Codes D1110 and D1120 Maximum Benefit	[\$10][\$15][\$20][\$25] per Cleaning [One][Two] cleanings per Covered Person per Certificate Year
Fluoride Treatment CDT Codes D1203;1204;1206 Maximum Benefit	[\$10][\$15][\$20][\$25] One treatment per Covered Person per Certificate Year
Radiographs (X-Rays) CDT Codes D0210-D0363 Maximum Benefit	[\$10][\$15][\$20][\$25] Once per Covered Person per Certificate Year
Amalgam Fillings CDT Codes D2140;2150;2160;2161 Maximum Benefit	[\$10][\$15][\$20][\$25] per amalgam filling [One][Two] per Covered Person per Certificate Year
Resin-Based Composite Fillings CDT Codes D2330-D2332; D2335; D2390- D2394 Maximum Benefit	[\$10][\$15][\$20][\$25] per composite filling [One][Two] per Covered Person per Certificate Year]
[Durable Medical Equipment Benefit]	
Maximum Benefit	[\$75-\$250] per device [one-five] devices per Certificate Year per [Covered Person][Family]

<u>[Hospital Confinement/Medical Facility Benefit]</u>	
Hospital Confinement Benefit	[\$50 – \$3,000] per day of confinement
Maximum Benefit	[5-100] days per Certificate Year per [Covered Person][Family]
<u>[Hospital Intensive Care Unit Confinement Benefit]</u>	
Maximum Benefit Period	Up to [5-100] days per Certificate Year per [Covered Person][Family]
<u>[Hospital Admission Benefit]</u>	
Maximum Benefit	[\$50-\$3,000] per admission [One-Five] admissions per Certificate Year per [Covered Person][Family]
<u>[Emergency Room Benefit]</u>	
Maximum Benefit	[\$50-\$1,000] per visit [1-5] Visits per Certificate Year per [Covered Person][Family]
<u>[Newborn Child Hospital Care Benefit]</u>	
Newborn Child Hospital Care Benefit	[\$100 - \$2,500] per day of hospital care
Maximum Benefit	[1–4] days of hospital care per Certificate Year, per newborn child
<u>[Surgery Benefit]</u>	
Maximum Benefit per Surgery	[50%-150%][2010] RBRVS
Maximum Benefit	[\$100-[Unlimited]] per Certificate Year per [Covered Person][Family]
<u>[Anesthesia Benefit]</u>	
	[25%] of surgical benefit]
<u>[Ambulatory Surgical Center Benefit]</u>	
Ambulatory Surgical Center Benefit	[\$250] per admission
Maximum Benefit	[Two] admissions per Certificate Year per [Covered Person][Family]
<u>[Pre-Admission Test Benefit]</u>	
Maximum Benefit	[\$50-\$500] per Surgical Admission [1-5] Surgical Admissions per Certificate Year per [Covered Person][Family]
<u>[Doctor's Office Visit Benefit]</u>	
Doctor's Office Benefit	[\$5 to \$200 in increments of \$5] per visit
Maximum Benefit	[1-7] visits per Certificate Year per [Covered Person][Family]
<u>[Preventive Care Office Visit]</u>	
Annual Preventive Care Office Benefit	[\$25-\$250] per Visit
Maximum Benefit	[1-3] visits per Certificate Year per [Covered Person][Family]
<u>[Diagnostic Tests, X-Ray and Laboratory Benefit]</u>	
[Tier One Diagnostic Test Benefit: MRI; CAT; PET; Colonoscopy; Bone Marrow Test; Stress Test]	[\$25-\$1,500] per test
[Maximum Benefit]	[1-2] tests per Certificate Year per [Covered Person][Family]
[Tier Two Diagnostic Test Benefit: Mammography; EEG; X-Ray; Breast Ultrasound; Sigmoidoscopy]	[\$25-\$500] per test
[Maximum Benefit]	[1-3] tests per Certificate Year per [Covered Person][Family]
[Tier Three Diagnostic Test Benefit: Blood test for triglycerides; CA 15-3; CA 125; CEA; eye exam; fasting blood glucose test; hemoccult stool analysis; PSA; serum protein	[\$5-\$100] per test

electrophoresis; thermography; cervical cytological screening; colorectal cancer screening; prostate cancer screening; child health screening]	
[Maximum Benefit]	[1-20] tests per Certificate Year per [Covered Person][Family]]
<u>Mental Health Benefit</u>	
Mental Health Inpatient Benefit	[\$50-\$3,000] per day
Mental Health Inpatient Maximum Benefit	[5-100] days per Certificate Year per [Covered Person][Family]
Mental Health Outpatient Benefit	[\$5-\$200 in increments of \$5] per visit
Mental Health Outpatient Maximum Benefit	[1-20] visits per Certificate Year per [Covered Person][Family]]
<u>Chemical Abuse and Dependence Diagnosis and Treatment Benefit</u>	
Chemical Abuse and Dependence Diagnosis and Treatment Benefit	[\$50-\$3,000] per day
Detoxification Maximum Benefit	[5-100] days per Certificate Year per [Covered Person][Family]
Inpatient Rehabilitation Maximum Benefit	[5-100] days per Certificate Year per [Covered Person][Family]
Chemical Abuse and Dependence Outpatient Benefit	[\$5 to \$200 in increments of \$5] per visit
Chemical Abuse and Dependence Outpatient Benefit Maximum Benefit	[1-7] visits per Certificate Year per [Covered Person][Family]]
<u>Accidental Death and Dismemberment Benefit</u>	
Accidental Death Benefit	[\$1,000-\$50,000] Primary Insured; 50% Spouse; 25% Dependent
Dismemberment Benefit	[\$1,000-\$50,000] Primary Insured; 50% Spouse; 25% Dependent Loss of both hands or both feet - 100% Loss of sight of both eyes - 100% Loss of one hand and one foot - 75% Loss of one hand and sight of one eye - 50% Loss of one foot and sight of one eye - 50% Loss of one hand - 25% Loss of sight of one eye - 25%
[Riders]	
<u>Ambulance Services Rider</u>	
Ambulance Services Benefit	[\$100-\$1,000] per Covered Sickness/Accident per Covered Person
Maximum Number of Conveyances	[3-6] per Certificate Year per Covered Person]
<u>Skilled Nursing Facility Benefit Rider</u>	
Skilled Nursing Facility Benefit	[\$100-\$1,000] per day of confinement
Maximum Benefit	Up to [60-90] days per Calendar Year per Covered Person]
<u>Term Life Insurance Rider</u>	
Term Life Benefit	[\$5,000-\$10,000]
[Covered Spouse [Domestic Partner] Life Insurance Amount]	[\$2,000 - \$4,000]
[Covered Dependent Children]	[Age 14 days, but less than 6 months [\$100] Age 6 months, but less than 26 years of age [\$1,000 - \$2,000]]]

16. Is this a replacement of similar coverage: ☐ Yes ☐ No

17. Previous Company: _____

Termination Date of Prior Plan: _____

It is understood and agreed that this application shall be attached as a part of the Policy applied for, and that no Insurance shall be effective until approved by American Medical and Insurance Company at its home office.

I understand that Accident and Sickness Medical Plan covered persons are covered by group insurance benefits. The group insurance benefits vary depending on plan selected. These benefits are provided under a group insurance policy underwritten by American Medical and Life Insurance Company and subject to the exclusions, limitations, terms and conditions of coverage as set forth in the insurance certificate which includes, but is not limited to, limitations for pre-existing conditions. This is not basic health insurance or major medical coverage and is not designated as a substitute for basic health insurance or major medical coverage. This is an accident and sickness medical plan that provides for limitations to the coverage for each benefit. The limitations are disclosed in the policy and certificate which are made available at the time of enrollment.

WARNING: It is a crime to provide false or misleading information to an insurer for the purpose of defrauding the insurer or any other person. Penalties include imprisonment and/or fines. In addition, an insurer may deny insurance benefits if false information materially related to a claim was provided by the applicant.

Dated at: _____
(City, State)

By: _____
(Authorized Signature/Title)

On: _____
Date (mm/dd/yyyy)

By: _____
(Printed Agent/Broker Name)

(Signature of Agent/Broker)

To be Completed by Home Office

On _____ By _____ Plan Effective Date _____
Date (mm/dd/yyyy) Home Office

SERFF Tracking Number: ICCI-127664494 State: Arkansas
 Filing Company: American Medical and Life Insurance Company State Tracking Number: 49909
 Company Tracking Number: AMLI OPTIONAL RIDERS
 TOI: H14G Group Health - Hospital Indemnity Sub-TOI: H14G.000 Health - Hospital Indemnity
 Product Name: AMLI Optional Riders
 Project Name/Number: AMLI Optional Riders /AMLI Optional Riders

Supporting Document Schedules

	Item Status:	Status Date:
Satisfied - Item: Flesch Certification Comments: Attachment: Cert of Comp. with Rule 19 AMLI Optional riders 9-28-11.pdf	Approved-Closed	10/04/2011

	Item Status:	Status Date:
Satisfied - Item: Application Comments: see form schedule tab	Approved-Closed	10/04/2011

	Item Status:	Status Date:
Satisfied - Item: Authorization Letter 2011 Comments: Attachment: auth letter _2011_.pdf	Approved-Closed	10/04/2011

**Certificate of Compliance with
Arkansas Rule and Regulation 19**

Insurer: American Medical and Life Insurance Company

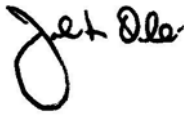
Form Number(s):

Ambulance Services Rider – GRP LM 2.0 ASR

Skilled Nursing Facility Benefit Rider – GRP LM 2.0 SNF

Policyholder Application – AMLI GRP LM 2.0 APP

I hereby certify that the filing above meets all applicable Arkansas requirements including the requirement of Rule and Regulation 19.



Signature of Company Officer

John Ollis

Name

CEO and President

Title

September 28, 2011

Date



8 WEST 38TH STREET – SUITE 1002
NEW YORK, NY 10018

MICHAEL F. MURPHY

EXECUTIVE VICE PRESIDENT & CHIEF MARKETING OFFICER

301.299.7802

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www.usamli.com

January 1, 2011

Mr. Brian Camling
President
Insurance Compliance Consultants, Inc.
3925 East State Street, Suite 200
Rockford, IL 61108

Dear Mr. Camling:

Please accept this letter as written confirmation that Insurance Compliance Consultants, Inc., has authority to file the attached form(s) or a state specific variation of it, and to act on behalf of American Medical and Life Insurance Company regarding such filings, in all jurisdictions where this form(s) or a state specific variation of it is being filed. American Medical may withdraw this authorization at any time, by giving notice to Insurance Compliance Consultants.

Sincerely,

A handwritten signature in blue ink, appearing to read "Michael F. Murphy", with a stylized, looping flourish extending from the end of the signature.